December, 2005

Washington State Department of Social & Health Services

Fact Sheet:

Comprehensive Assessment and Reporting Evaluation for Long Term Care

CARE

The Beginning

1995

House Bill 1908, passed in 1995, required that the Aging and Disability Services Administration develop a new classification and payment methodology that would tie payment for community based long term care services more closely to clients' needs. The new methodology would need to more appropriately and equitably provide funding to match the complexity of the care being delivered.

Complying with Federal Mandates

1997

The funds for the care of long-term care clients are approximately fifty percent federal Medicaid monies. Due to that fact, Washington State is subject to periodic audits by the Centers for Medicare and Medicaid Services (CMS – formerly the Health Care Financing Administration). In 1997, the federal representatives audited our program to ensure that care was being delivered to clients who are eligible for the program. The auditors found a number of instances where payments were not authorized in accordance with the Medicaid program rules. A new system that standardized documentation would ensure that case managers properly allocate services and authorize payment according to program rules. Such an improved system would greatly reduce the risk of future negative audit findings.

The Ladd Report

1998

Under contract to the Office of Financial Management and the state Senate, an outside consultant reviewed the Washington long-term care system in 1998. The report produced is commonly referred to as the "Ladd Report". The report notes "*The present computerized CA* (Comprehensive Assessment) *does not take full advantage of the power of computerization to integrate eligibility, assessment findings, authorized hours, and the care plan."* The report further noted that "It is probably not possible for the CA to be able to classify clients according to impairment levels, as it presently exists" – meaning the current CA tool was inadequate to meet legislative and payment system requirements."

FOR MORE INFORMATION, CONTACT:
Terry Rupp, Program Manager, Home and Community Services, Aging and Disability Services Administration, 725-2353

The Joint Legislative and Executive Task Force on Long-Term Care also recommended major changes to the Comprehensive Assessment tool such as including more detail on complex medical needs, cognitive impairment, and behavioral problems; increasing the assessment's "inter-rater reliability" to provide more consistent evaluations between assessors; and encouraging broader use of the CA throughout the long-term care system.

Finding the Right Assessment Tools

2000

The foundation of the CARE assessment tool is the Minimum Data Set (MDS). The MDS provides a core set of data elements that have proven to be reliable and valid in assessing and screening for the medical, functional and psychosocial needs of clients. Since the creation of the MDS model for nursing facilities, MDS models have been designed and implemented in post acute care rehabilitation, mental health, assisted living facilities, palliative care and in-home care. The MDS methodology was field tested to determine its inter-rater reliability. In other words, would two social workers get the same results with the same client? Clients were assessed by Home and Community Services social workers using the MDS that later became CARE. Within the same week, a worker from the University of Washington assessed the same client and the results were compared. The CARE tool demonstrated that it is reliable between different workers.

In addition to the MDS, ADSA utilized proven standardized screening tools to increase assessment accuracy and reliability. These tools include the Mini-Mental Status Exam, The Centers for Epidemiological Studies (CESD)-Iowa Depression Scale, the Cognitive Performance Scale, The Zarit Burden Scale, and an Alcohol/Substance Abuse screening tools.

Developing a New Payment System

2001-2002

During 2001 and 2002, ADSA conducted a time study in boarding homes, adult family homes, and clients' own homes in several communities across the state to determine resource use when specific care needs were identified. Trained social and health service professionals visited several hundred clients and collected data on clinical characteristics and need for assistance in performing activities of daily living. Care time was tracked for three consecutive days with the data gathered on each client being matched to the amount of time providers spent caring for the client. The results were used to develop the new payment methodology that tied client characteristics to resource use.

The CARE tool provides consistency in determining need and allotting resources to meet the determined need.

Developing New Software

2002

In March, 2002, ADSA contracted with Deloitte Consulting for one year to develop a software application to be used by assessors on laptop computers. Deloitte had developed a similar application for Oregon which was adapted for Washington using the new assessment tool and payment algorithm.

A Joint Requirement and Planning Committee (JRP) made up of social workers and case managers from around the state provided clinical advice and testing of the software to assure the complex algorithms within the tool, as well as the functionality, were operating as intended.

In addition to the payment algorithm, CARE determines a client's program eligibility as well as the need for a possible nursing referral by displaying critical indicators triggered by the client's clinical characteristics. CARE also contains a Skin Observation Protocol algorithm, which is triggered by certain risk factors identified in the assessment. These and other features, including the extensive reporting capability, have made CARE an asset to clients, field staff, and management.

Implementing CARE

2003-2004

CARE's implementation involved the training of 1,000 workers over a time period of 11 months beginning in April 2003. Members of the JRP along with the Quality Assurance staff participated as trainers, with JRP members remaining in the field as local CARE experts. All long-term clients and applicants are assessed in CARE by a social worker or case manager using a laptop computer in the client's residence or facility setting.

Because the legislature has required that the implementation of CARE be budget neutral, expenditures have been closely monitored since the beginning of rollout. While the average expenditures have varied less than 1% from 2003 to 2004, some clients have seen increases, some have seen decreases, and many have seen little or no change. Before CARE, many clients were grouped by program or policy limits. For example, many DDD clients received 96 hours because the client lived with a parent provider. With CARE, this limit has been lifted and many clients have moved either up or down, depending upon their clinical characteristics. Many other clients were grouped at 112 hours, the agency limit; 144 hours, the MPC limit; and 184 hours, the COPES limit for HCS clients. These clients may also have seen changes in hours.

CARE's Future

2006

The Divisions of Developmental Disabilities (DDD) and Home and Community Services (HCS) are working together to develop an expanded tool that wil be used to assess all current and potential DDD clients for services ranging from waiver funded supported living and other group settings to family and employment support. The expanded version of CARE is expected to be completed by the end of 2006.

Visit our website at www.adsa.dshs.wa.gov